

Department of Health Care Services









Denti-Cal Application Package DHCS 5300 Overview

December 19, 2016

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CA Department of Health Care Services



Welcome to DHCS 5300

This webinar will elucidate the Denti-Cal provider community on the newly created DHCS 5300 form, a streamlined Denti-Cal specific enrollment application.

- The DHCS 5300 stems, in part, from the Department's commitment to making significant improvements to the Denti-Cal program, as well as the voiced feedback and considerations of stakeholders in the program.
- Each page along with the features of the form shall be addressed and discussed upon individually and in relation to corresponding page(s) from the existing Medi-Cal enrollment package.
- All pages of the DHCS 5300 form are presented on the left-hand side of the slides, while the cross-referenced DHCS 6207, DHCS 6208, DHCS 6203, & DHCS 6204 forms are represented on the right-hand side.





Dear Applicant

Thank you for your recent inquiry regarding participation in the Medi-Cal Dental Program (Denti-Cal). Please complete the enclosed Denti-Cal provider enrollment application backage and return it to:

Medi-Cal Dental Program, Provider Enrollment P.O. Box 15609 Sacramento. CA 95852-0609

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned. It is your responsibility to report to the Denti-Cal Program any modifications to information previously submitted within 35 days from the date of the change. Most changes, such as a change of ownership that is less than 50 percent, may be reported on a Medi-Cal Supplemental Changes (DHCs 6209) form. However, you must complete a new application package if you are reporting a change of ownership of 50 percent or more, or one of the other changes identified in California Code of Regulations, (CCR), Title 22, Section 51000.30, subsections (a) though (b).

PLEASE NOTE: All providers must be enrolled in the Denti-Cal program prior to rendering services to a Medi-Cal beneficiary. Group providers must continue to confirm the enrollment of all rendering providers prior to allowing the rendering providers to issue services to Medi-Cal beneficiaries. Denti-Cal program will not pay for services, if the rendering provider is not enrolled.

Applicants and providers are required to submit their National Provider Identifier (NPI) with each Denti-Cal provider application package. A copy of the CMS/National Plan and Provider Enumeration System (NPPES) confirmation document for each NPI listed in the application package must also be included. Current Denti-Cal providers are required to submit both the NPI and any Denti-Cal provider numbers issued previously on any application forms submitted to the Denti-Cal Program.

If you are planning to sell your business or buy an existing business, you may find it helpful to refer to the Denti-Cal Provider Application Forms page at www.denti-cal.ca.gov. The Provider Application Forms page contains information about enrollment options available to you whenever there is a sale or purchase of a Denti-Cal enrolled provider or business, including the option to submit a Successor Liability with Joint and Several Liability Agreement (DHCS 6217).

For more information about enrollment forms and the regulatory requirements for participation in the Denti-Cal Program, please review the Provider Handbook, Section 3 on the Denti-Cal web site listed above or if you have any questions, contact the Telephone Service Center at 1-800-423-0507.

Sincerely,

Denti-Cal
California Medi-Cal Dental Program
Provider Enrollment

Enclosures

P.O. Box 15609 • Sacramento, CA 95852-0609 • (800) 423-0507 • (916) 853-7373



- Applicants/providers must read this page carefully, as it directs them to the appropriate form(s) to fill for their enrollment purposes.
- The majority of page A-1 of DHCS 5300 form mirrors the page A-1 of DHCS 6203 & DHCS 6204 forms. The exception lies in the critical paragraph—that has been boxed with a red line, where applicants/providers are informed of the appropriate forms to complete for enrollment.



GENERAL INSTRUCTIONS FOR COMPLETING THE DENTI-CAL PROVIDER APPLICATION

This form is the application for enrollment or continued enrollment as a provider in the Denti-Cal program. Applicants and providers must also provide additional information and documentation. Applicants and providers may be subject to an on-site inspection and to unannounced visits prior to enrollment or approval for continued enrollment in the program. Additional information can be found on the Denti-Cal Web site (www.Denti-cal.ca.gov) by clicking the "Provider" link.

This page is the instruction page of the DHCS 5300, where definitions for the required fields are provided to the applicant/provider. This page combines and abridges the instructional pages of the DHCS 6203 & DHCS 6204 forms (4 pages) into a dental specific instructional pages.

MEDI-CAL PROVIDER GROUP APPLICATION

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Enrollment action requested - check all that apply. Enter the date you are completing the applic

"New provider" - check if the applicant is not currently enrolled in the Medi-Cal program as a provider with an active provider number, Include the NPI (or Derti-Cal provider number it applicable) for the business address indicated in term 4. "Change of business address"—check if the applicant is currently enrolled in the Med-Cal program and is requesting to relocate to a new business address and vacate the old location. Indicate the business address applicant is moving from

"Change of ownership"—check if there is a change of ownership as defined in Title 22, CCR, Section 51000.6. Indicate the effective date in the space provided.

ve change of 50 percent or more in person(a) with ownership or control interest"—check if there is a cumulative erri or more in the person(s) with ownership or control interest, as defined in Title 22, CCR, Section 51000.11 also provided in the last comprets application peckage Talk was approved for erroritiment. Indicate the effecti

ordinant"—check if the applicant is currently enrolled as a Modifical provider and has been requested by the apply for continued enrollment in the Medifical program. Do not check this box unless you have nocived in the Medifical program. Do not check this box unless you have nocived in the Department, pursuant is The 2D, CCP. Section 55000.55. List current provider number(s) in the space provider.

corporate number and state in which incorporate if you check "other," list the type of legal entity.

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"Business address" is the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit 2IP code. A post office or commercial took is not acceptable.

county, team, and managing or 1000s. A page order or incommensure to an assequence.

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"Pay-to address" is the address to which payment will be mailed. The pay-to address should include, a post office box number, street number and name, room or suite number or latter, city, state, and nine-digit

"Making address" is the address at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.

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10. Enter the Selen's Permit number issued by the State Board of Equatization. Attach a legible copy of the Selen's Permit.

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13. If this is a physician provider group, or dential provider group, list the specialtydes:

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DHCS 6204

(a) To which an applicant or provider has contracted or delegated some of its management functions or responsibilities of providing healthcare services, equipment or With whom an applicant or provider has entered into a contract, agreement, purchase order, lease, or leases of real property, to obtain space, supplies,

"Payb address" is the address to which payment will be mailed. The pay-to address should include as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.

"Previous business address" is the address where the applicant or provider was previously enrolled. If the applicant or provider is not

submitting an application for a change of location, enter N/A. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the provider entity; or enter social security number

Enter any local business license or permit numbers for any city and/or county where you conduct your business. If this does not apply to

10. Enter the information for your General Liability Insurance Policy. This policy covers the contents of the building and is separate from your Professional Liability Policy.

Enter the information for your Professional Liability (Malpractice) Insurance Policy.

12. Check the box for your Workers Compensation Insurance Policy. If you do not have this policy mark N/A and explain why.

List the name, Type 1 NPI, dental license number, specialty, and email address for all rendering providers in the provider group. Attach additional sheets, if necessary. Rendering providers not already currently enrolled as Denti-Cal providers who are enrolling to render services in the provider group must use the "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied/Dental Providers" (DHCS 6216) in addition to being listed in this question.

14 -18. Read and answer the questions.

Read and return the Terms and Conditions on pages 9-15.

19-21. Enter the information requested on page 15 to include an original signature, in ink, of the applicant/provider

DHCS 5300 (rev. 11/16)

DO NOT USE stagles on this form or on any attachments.

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Omission of any information or documentation on this form or failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.

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Type of entity"—check the tox which applies to your business structure. Your corporate status will be verified using the opporate number and state in which incorporated. If a partnership, you must attach a legible copy of the partnership agreement. If you check forther, it as the your disposit entity.

2. "Business name" is the name of the applicant or provider if different from that listed in number 1, if this is a follows business name, provide the Fictious Business Name Statement/Permit number and effective date. Attach a legible copy of the reconsolidations of pulsariess Name Statement Permit to the application.

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"Previous business address" is the address where the applicant or provider was previously enrolled. If the applicant or provider is not submitting an application for a change of location, enter NA.

8. Enter the license/certificate number, or other approval to provide health care, of the applicant or o

Enter the Taipayer Identification Number (TIN) issued by the IRS under the name of the approach legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification)

15. Nume Practitioners projumenter pinical and didantic training or equivalent experience pormissed. Also

Enter the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach is legio certificate. If this does not apply to you, writer "NA".

Enter the State Laboratory License/Registration number. Atland a legible copy of the license/registration. If this does not apply to you, enter NIA.

20. Proof of Professional Liability Insurance—enter the name of the insurance company, insurance policy number, date policy issued, expiration date of policy, insurance agents name, telephone number of the insurance agent and enail address of the insurance agent and enail address of the insurance agent. You must attack a copy of your perificate of insurance to the

22. Enter the date of birth of the individual named in number 1, if applicable. If not applicable, enter NA.



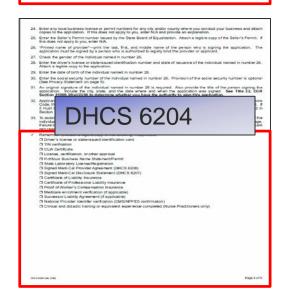
Checklist of items to supplement the application form(s):

- National Provider Identifier (NPI) verification (CMS/NPPES verification) Type 1 and 2 as applicable
- IRS Tax Identification Number verification pre-printed by the IRS (if using a TIN to report earnings)
- Form W-9 (if using a Social Security Number to report earnings)
- Stamped/endorsed copy of Articles of Incorporation (if enrolling as a corporation)
- Stamped/endorsed copy of Complete Statement of Information to include all officers/directors (if enrolling as a
- ☐ Fictitious Name Permit from the Dental Board of California for this location (if you use a name other than your legal given name or legal entity name)
- Additional Office Permit from the Dental Board of California (if you own or have ownership in more than one dental office)
- Business License/Tax Certificate
- Certificate of General Liability Insurance for the business address
- Certificate of Professional Liability (malpractice) Insurance
- Proof of Worker's Compensation Insurance for the business address
- Department of Health Care Services Permit (if you are enrolling as a clinic)
- Letter appointing a dental director (if you are enrolling as a clinic)
- Bill of Sale (if you have bought or sold the office in which you are enrolling)
- Successor Liability Agreement (notary is required for this form when used for sale of practice, only when applicable)
- Full lease agreement including any sub-lease agreements and/or modifications (if you lease your building/space)
- Driver's license or state-issued identification card of individual signing the application
- Dental license
- DEA certificate (if applicable)
- Orthodontia provider certification (form DC015) (if enrolling as an orthodontist)
- Any other certificates pertaining to your practice of dentistry (example: specialty, general anesthesia)
- Management agreement (if someone other than your office staff manages/runs your practice)
- Complete "Medi-Cal Rendering Provider Application/Disclosure Statement/Agreement for Physician/Allied Providers" (DHCS 6216) for each rendering provider being added to the provider group if the rendering provider is not currently enrolled as a Denti-Cal Provider or a currently enrolled provider is due for revalidation.

This page serves as the reference checklist for applicants/providers. The applicant/provider should refer to this page before submitting their DHCS 5300 form. The checklist possesses a list of supplemental documents the Department may require of the applicants/providers in order to enroll them into the Denti-Cal program.

DHCS 5300 (rev. 11/16)

DHCS 6203 Enter the social security number of the individual named in number 22. Provision of the social security number (see Privacy Statement on page 6).





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The red box contains content from the DHCS 6203 & DHCS 6204 forms with four significant changes.

- There is added information about the web aid tools for providers to employ in completing this package.
- 2) The Medi-Cal return address has been removed. Hence, applicants/providers are expected to return the completed package to the available Denti-Cal address.
- 3) There is a required field for the types of NPI the applicant/provider may possess and the business type.
- 4) The repetitive request for the effective date of the ownership change has been deleted.



DHCS 5300 Page 4 (cont)

State of C	illumia—Health and Human Services Agency	Department of Health Care Services
	DENTI-CAL PROVIDER APPLICATION	ı
Typ. If you Do Vis	ant: d all instructions before completing the application. e or print clearly, in ink. u must make corrections, please line through, date, and initial in ink (do not use whiteout). not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you. If the Denti-Cal Website for helpful tools to aid in completing this package. urn completed forms and all applicable attachments to: - -	FOR STATE USE ONLY
Qı	uestions 1-4, combine the question	ons relating to

Questions 1-4, combine the questions relating to the provider's name and business name present separately in the DHCS 6207, 6208, 6203, & 6204. This is the only section of the DHCS 5300 where providers will need to provide this information. DHCS 5300 also ascribes the term "business name" as a synonym to "fictitious name," to alleviate the confusion both terms.

State incorporated:	State registered/filed		_	Other:		
Legal name of applicant or provider (as	s listed with the IRS)					
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Fictitious name as listed with the Dental	Board of California (include permit num	ber)		 Business telephone num 	ber	
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If the above location is leased or sub-leased compl original lessor's consent to	ete the following information regarding the le sub-lease). If the property is privately-owned	essor and enclose a copy of your sig d or a letter is attached proceed to q	uestion 4g.	C. Has the applicant/provider had any population translations with any wholly cented supplier or with any substitution and leaf or of Park Journey to 4-year previous immediately preventing the date of this Population. Tophical hadrones to prevent of more any physicism for securities of the section of preventing the date of this groups, capital, or references existed to the previous of services to select its sections set, saving any on these preventions.
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Name & title	SubcontractorName	Address	Ownership %	If Yes, complete the following information about the supplier or subcontractor: Colournization's or suppliers fall legal name 2. Subcontractor's or suppliers printer number 2. Subcontractor's or suppliers printer number
Name & title	SubcontractorName	Address	Ownership %	Discontraction or register screen (number, close) (chip) (State: (num-digit 20° close) Discorde his linearization).
4h. Does the applicant have any other significant busin if ves, describe on an additional sheet of paper, the tra			.23 (see instructions)? Yes No	If here is more than one subcombastor or supplier, provide a separate sheet with all required information (sheel "Authorial Section 1, Part C)

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6204

Questions 10-13 streamline the required information for the general & professional liability, workers compensation, and the rendering provider information from both DHCS 6203 & 6204 respectively. Additionally, fields pertaining to medical treatment e.g., hospital privileges were eliminated.



DHCS 5300 Page 5 (cont)

5. Pay-to add	ress (number, street, P.(D. Box number)		City				State	Nine-digit ZIP code
	ige of business addres: usiness address (number	s, enter location moving f	from (If none, ma	rk N/A an	d continue to q	uestion 7):		State	Nine-digit ZIP code
6. Previous bu	aliness address (number	r, sueet)		City				State	Nine-digit ZIP code
7. Taxpayer ld Proprietor	entification Number (TIN not using a TIN	I) issued by the IRS/or SSN	i l'Sole	8. Local	business licens	se/Tax permit number	9. Gende	er .	
10. Proof of G	eneral Liability Insurance	e (business address covera	ige)						
Name of in	surance company								
Insurance	policynumber		Date policy iss	sued(mm/	dd/yyyy)		Expiratio	n date of policy	r(mm/dd/yyyy)
11. Proof of Pr	rofessional Liability Insur	rance (majoractice)							
	surance company								
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
Insurance	policy number		Date policy iss	sued(mm/	dd/yyyy)		Expiratio	n date of policy	r(mm/dd/yyyy)
12. Does the a	nolicant have Worker's (Compensation Insurance as	required by state	law ²			Ye	5 I N	0 N/A
If applicabl	ie, attach proof of mainte	enance of Worker's Compe	nsation insurance	. If not app	plicable, check I	N/A and provide an exp	lanation be	elow:	
13. List all pro	viders rendering services	s to Denti-Cal beneficiaries	including yourself	f (attach a	dditional sheet	f necessary, labeled ad	ditional qu	estion 13)	
	Name	NPI type 1	Dental lic	ense		Specialty		Ema	il address
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	EDI-CAL DISCLOSURE STA		
APPLICANT/PROVIDER IN	lines, etc., blank. Check or enter NA it FORMATION	not applicable to you.	
A, Legal name of applicant provider a			
is the care of work and require	s it appears on professional foence - IF NOT APPL	CARLE CHECK THE BOX III	v a
C. Existing provider numbers (neht or	Dero-Cai provider number as applicable) used at th	e address indicated in tiem G bed	™ L NA
D. If applying as a rendering provider	to a provider group, check here 🗌 and proceed to	Fat I (marked with testinglish bed	M2 -
Fottous tuainess name N/A			
F. "Doing Business As" name N	M		
G. Address where services are render	red or provided (number, sitest) (City)	(908	e) (Mine-og), SP 0000
Does applicant/provider lea	se this location?	□ No	-
 F YES, complete the folio Agreement, including any Application. 	owing information regarding the Lessor and sublease agreements entered into by the	enclose a copy of the o applicant provider at the bus	urrent signed Lear iness address on th
a Lesser harre			
5. Lessor address (number, e	men (Oty)	7500	ii Nni-dgi EP ook
L. Leson Westhorn number	Id. Tempf ease	la Acous d'asse	
- Author school south	W. 1501 D. 8469		
3. If no, does applicant/provide		□ No	
4. If applicantiprovider does no	of lease or own this location, explain below:		
H. Type of Entity (must check one	d:		
☐ General Partnership	☐ Limited Partnership		bility Partnership
Enoiste Partnership Agree Sole Proprietor (Unincorpor			artnership Agreemen Hali
Corporation (Enclose Articles of Incorpo	_	State incorporated	
Statement of Information	Services Coupling Contract	- Longer and	
comment of sections	Check one:		
☐ Nonprofit.		Other (specific)	
□ Nonprofit: Check one: □ Corporation □ Unincorporated Associal	Chartable (1)		
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OWNERSHIP INT	TEREST AND/OR MANAGING CONTROL INFOR	MATION (ENTITIES)	
separate Section	w, fist all corporations, unincorporated associations, partnership up or control interest, or any partnership interest, in the ap- n III. Part B and C for each entity listed below. Number of p this section does not apply and proceed to Section IV.	plicantiprovider identified in Sa	or more (dire
	ENTITY LEGAL BUSINESS HAME	PERCENT (N) OF OWNERSHIP OR CONTROL	NFI NUMBE (F APPLICAS
1.		1	
2		3 (
3.			
4			
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10.			
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17.			
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20			

Although question 14 of DHCS 5300 mirrors question "I" of DHCS 6207, its location is different and is more expedient for the applicant/provider in filling out the form. Question 15 on the other hand simultaneously reduces the filling space as shown in DHCS 6207, III(A), and adds in new columns: Tax Identification Number (TIN) and NPI type 2 information. The inclusion of these fields in this section avoids any unnecessary duplicate ownership information disclosures pertaining to entities.



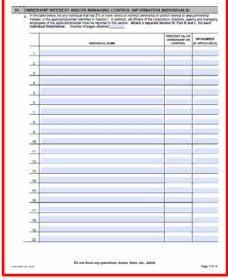
A. E	ntity with (Direct or Indi	rect) Owne	rship Interest and/or M	anaging Control-	-Identification Infor	mation.				
1.	Legal business nam	e								
2.	. Fictitious name (if a	pplicable)								
3.	. Primary Business A	ddress" (nu	mber, street)		(City)		(State)	(Nine-digit	ZIP cod	
	V									
	* If this entity is a corpo	oration, att	ach a list of ALL busine	ss location addre	sses and P. O. Bo	xaooresses	or the corporation	1.		
4.	Check all that apply:	ation to to a constraint		oles control	- Boston	- Oth-	. (
	5% or more owner		_	ging control	Partner	Uthe	er (specify):			
5.	Effective date of owne	ership and	control (mm/dd/yyyy):							
	spond to the following									
1.	Within ten years fro any government prog	ram?			onvicted of a fel	ony or misde	emeanor involving		ise in 'es 🔲 l	
	If yes, provide the da	ite of the co	enviction(mm/dd/yyyy):							
2.	Within ten years fro				n found liable for f	raud or		_		
	abuse involving any g	overnment	program in any civil p	roceeding?				Yes		
	If yes, provide the da	te of final ju	idgment (mm/dd/yyyy):							
3.	Within ten years fro		e of this statement, holving any government		ered into a settlem	ent in lieu o	f	Yes		
			ttlement(mm/dd/yyyy)						_	
	. Does this entity curre							Yes		
7.			ledicaid program? If ye				program in			
				NAME(S)				NPI AND/OR PROVIDER NUMBER(\$)		
	STATE		(1	LEGAL AND DB	A)		PROVIDER	NUMBER(S)		
5.	. Has this entity ever b	een suspe	nded from a Medicare,	Medicaid, or Med	li-Cal program?			Yes		
	If yes, attach verifica	tion of rein	statement and provide	the following info	rmation:					
	CHECK									
	APPLICABLE PROGRAM	PR	NPI AND/OR OVIDER NUMBER(S)	EF	FECTIVE DATE(S SUSPENSION) OF	DATE(S) OF R AS A	EINSTATEM PPLICABLE	ENT(S	
	Medi-Cal									
	Medicaid Medicare									
	Medi-Cal									
	Medicaid Medicare									
6.	 List the name and ac ownership or control 			s, participating or check here.	not participating i	n Medi-Cal,	in which this enti	ty also has a	n	
	If additional space is ne	eded, attac	h additional page (label '			ber of page	s attached:			
	a. Full legal name o	f health ca	re provider (include an	y fictitious busine	ess names)					
	b. Address (number	etenat)			(City)		(Cintal)	(Nine-digit ZI	D ood-	



Question 16, is the follow up inquiry on the ownership disclosure for the entities. The only significant change made to this question from its corresponding DHCS 6207. III(B) is the replacement of the "Doing **Business Name**" field with the "Fictitious name" field.



	app	he table below, list any individual that olicant/provider identified in question 1 olicant/provider must be reported in thi	I. In addition, all of	officers of the corporat	ion, directors, agents and	managing employees	rest, in the of the	
	Nu	mber of pages attached:	NAME		PERCENT (%) OF OWNERSHIP OR CONTROL	Social Security Number (SSN) (Required)	NPI TYPE 1	
	1							
	2	2.						
	3	3.						
	_ 4	l.						
	5	j.						
18.		OWNERSHIP INTEREST AN	D/OR MANAG	ING CONTROL	INFORMATION (INC	DIVIDUALS)		
Α.	lder of ti	ntification Information - for Individuals he Partnership, Group Association, C	with Ownership o orporation, Institu	r Control Interest, Officition or Entity.	ers, Directors, Managing	Employee(s), Partners	and/or Agents	
	1.	Full legal name (Last) (Jr., Sr., etc.)		(First)		(Middle)	
		Residence address (number, street)		(City	_	(State) (Nine	-digit ZIP code)	
				(34)		(2.2.2)		
	3.		ver's license num lttach a current a	ber or state-issued id nd legiblecopy.)	entification number			
		Is the above individual related to any i			?	C	Yes No	
		Spouse Parent	Child	Sibling	Self Ot	her (explain):		
		Name of individual:						
	6.	If the above individual is directly ass applicant/provider? Check all that ap	ociated with the e	entity identified in ques	tion 1, what is this individ	ual's relationship with t	he	
		5% or greater owner		artner	Managing employee	Agent	Self	
		Director/officer, title:			Other (sp	pecify):		
	7.	If the above individual is <i>directly</i> ass a. Legal business name of entity as			ion 15, indicate the name	of that entity in the spa	ce below:	
		b. What is this individual's role with						
		5% or greater owner	☐ Pa	irtner	Managing employee	Agent		
В	Res	Director/officer, title: spond to the following questions:			Other (spec	city).		
-		Within ten years from the date of t	his statement, h	as the above individu	al been convicted of any			
		felony or misdemeanor involving fraud					Yes No	
		If yes, provide the date of the convict						



Similar to question 15, question 17 simultaneously reduces the filling space as shown in DHCS 6207, IV(A), and adds in new columns: Social **Security Number** (SSN) and NPI type 1 information, for the same purposes earlier discussed in slide 10.



DHCS 5300 Page 7 (cont)

		OWNERSHIP INTE	REST AND/OR	MANAGINO	CONTROL	L INFORMATIO	N (INDIVIDUALS)	
	арр	e table below, list any ind icant/provider identified i icant/provider must be re	n question 1. In additi	ion, all officers	of the corporat	ion, directors, agent	s and managing emplo	o interest, in the yees of the
	Nun	ber of pages attached:						. NPITYPE 1
			INDMIDUAL NAME			PERCENT (%) C OWNERSHIP O CONTROL		N)
	1							
	2							
	3							
	4							
	5							
18.	(WNERSHIP INTER	REST AND/OR M	ANAGING	CONTROL	INFORMATION	(INDIVIDUALS)	
		Full legal name (Last) (Jr.,			(First	,		(Middle)
	2.	Residence address (numb	per, street)		(City)	(State)	(Nine-digit ZIP code)
	2 1	Date of birth	Id Driver's France		etate increaded	entification number		
	3. 1	Date of birth		urrent and legil		enuncation number		
	_							
		s the above individual rela f yes, check the appropria			n 17 and/or 4g	?		Yes No
		Spouse Pa	arent Ch	ild [Sibling	Self	Other (explain):	
		Name of individual:						
	6.	If the above individual is on applicant/provider? Check	directly associated w k all that apply.	ith the entity id	entified in ques	stion 1, what is this in	dividual's relationship	with the
		5% or greater owner		Partner		Managing emplo	yee Agen	Self
		Director/officer, title:				Oth	er (specify):	
	7.	If the above individual is o	directly associated w	ith an entity ide	entified in quest	tion 15, indicate the r	name of that entity in th	e space below:
		a. Legal business name	of entity as listed in o	question 15:				
		b. What is this individual	s role with the entity	reported in qu	estion 15? Che	eck all that apply.		
		5% or greater own	ier	Partner		Managing emplo	yee Agen	t
		Director/officer, titl	e:			Other	(specify):	
	Res	oond to the following ques	stions:					
В.	1.	Within ten years from t					any	
В.		felony or misdemeanor in	volvino fraud or abuse	in any govern	ment program	?		Yes No
В.	1	leiony or misoemeanor in	volving iradu or abuse	an any govern				

	List the name and a	others of a	I health care prov	idem, participating or not	participating	in Mei	FCK, in	which	
	atach additional page (abel "Additor	ral Section I, Part J's	DNA					
	1. Full legal runne of heat	in care provide							
	2. Address (number sine	et)		(09)		(0000)	(New-digit	DP 00	
К.	Respond to the following	g questions:	Maria de la compansión de						
	Within nen years of of any felony or miss	f the date of terrespor invi	this statement, has dving fraud or abuse	e you. The applicant/provider in any government program	been convic	Hell .	El Yes		
	If yes, provide the di	ate of the con-	vision (mm/95/yyy)	ENGVEN	9	_			
	2. Within on years of for fraud or abuse in	the date of a	his statement, have emment program in a	you, the applicant/provider, any civil proceeding?	been found lia	ble	D Yes	-	
	If yes, provide the di	ete of final jud	greet (mn/66/yyy)	200		_			
	3. Within ten years of settlement in lieu of	Within ten years of the date of this statement, have you, the applicant/provider, entend interest in lieu of conviction for that or abuse involving a government program?							
	If yes, provide the six	ste of the sett	ement (mm/dd/yyyy)		-				
	 Do you, the applica the Medi-Cal program 	ntiprovider, or m or in anothe	umently participate or or state's Medicaid pr	r have you ever participated ogram?	as a provide	in	□ Yes	D	
	If yes, provide the fo	lowing inform	ation.						
	STATE			(YEOM' TWO DEM)			NOTES NUMBER		
	10								
						_			
		20000000					-	-	
	Have you, the applicant/provider, ever been suspended from a Medicare, Medicaid, or Medi-Call program? Wes No.								
		If yes, attach verification of reinstatement and provide the following information:							
	If yes, attach verifica			re rangering crommanum.	1	V 0.1.			
	If yes, attach verifical CHECK APPLICABLE PROGRAM	140	I AND/OR ER NUMBER(3)	EFFECTIVE DATE(S) O	047	10 (0)	REINSTATES	MENT	
	CHECK APPLICABLE PROGRAM	140	ANDION	EPPECTIVE DATE(S) O	047	40.0	NEWSTATE PPLICABLE	MENT	
	F yes, attach verifical CHECK APPLICABLE PROGRAM Medical Medicare Medicare	140	ANDION	EPPECTIVE DATE(S) O	P 043	4.5 /	PPLICABLE	MENT	
	Fyes, attach verifical CHECK APPLICABLE PRODUCAM Medicard Medicard Medicard Medicard Medicard Medicard	140	ANDION	EFFECTIVE DATE(S) O SUSPENSION	P DATE	4.9.1	PPLICABLE	MENT	
	Fyes, attach werfest OHECK APPLICABLE PRODUM Medicard Medicard Medicard Medicard Medicard Medicard Medicard Medicard Medicard To this the individual is ever been tuspend	IRROVIDE	I ANDOOR OR NUMBER(S)	EFFECTIVE DATE(S) O SUSPENSION	e applicant/or	A.S. A	PPLICABLE		
	If yes, attach verifical CHECK APPLICABLE PROCESSAN PROCESSAN Medicard Medicard Medicard Medicard Medicard Medicard Medicard Medicard Sever been suspend over them those your from them that you were Actionals	introvide onnse, centric ed or revoked es, of formain professional	I ANDOOR OR NUMBER(IS) also, or other approve T g authority's decision privileges have been	EFFECTIVE DATE(S) of SUSPICIASION If the provide health care of the not) for each decision and restored and provide the following to restored and provide the following the followi	e applicantion	AS A section section.	PFLICABLE ☐ Yes Out TE(5) Or		
	If yes, attach verifical CHECK APPLICABLE PRODUCEM Medicard Medicard Medicard Medicard Medicard Medicard Sylver been suspend of the medicard sylver been suspend from them to your from them to your from them to your	introvide onnse, centric ed or revoked es, of formain professional	I ANDOOR OR NUMBER(IS) also, or other approve T g authority's decision privileges have been	EFFECTIVE DATE(S) O SUSPENSION If to provide health care of the	e applicantion	wider sation son.	☐ Yes		
	If yes, attach verifical CHECK APPLICABLE PROCESSAN PROCESSAN Medicard Medicard Medicard Medicard Medicard Medicard Medicard Medicard Sever been suspend over them those your from them that you were Actionals	introvide onnse, centric ed or revoked es, of formain professional	I ANDOOR OR NUMBER(IS) also, or other approve T g authority's decision privileges have been	EFFECTIVE DATE(S) of SUSPICIASION SUSPICIASION E to provide health care of the not) for each decision and restored and provide the following to provide the following control of the following c	e applicantion	AS A section section.	☐ Yes		

A, Funlegatione (Leat) (ut. St. etc.)	(Frest)	(Moa
B. Residence address (number, street)	(09)	(State) Nave-digit.
C. Social security number (requires)		
D. Date of sings		
E. Driver's livense number or state-sound identification of	CONTRACTOR CONTRACTOR	
If you, the applicant/providenter	der are an unincomorate	ut colo empriotor
proceed to Section V.		su soie-proprietor,
	OR	
 If you, the applicant/proviogroup, proceed to Section 		ider adding to a
group, processes to contin		

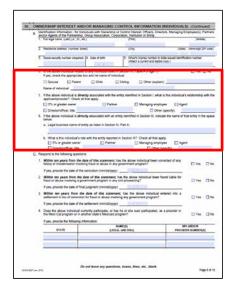
2.	M	dior Agents of the Partnership	p. Group Association, Corpo.		Managing Em		
	1.	Fur legal name (pain) (ur., br.,	ec.)	(FIRE)		Mos	•
	ž	Assidence address (number, o	(Medi)	(Caly)	(ftile)	(Mne-digit 2	(P 1004)
	I	Stock security number insquire	e. 4. Case of same	Onuers scanse number or scale-is (Atlach a current and legible cook.)		on number	
	6.		ed to any individual listed in : box and list name of individ	Section IV, Table A (Page 7)?		□ Yes	□ No
		Spouse Parent	D0M D	Sking 🗆 Other (explain) 🔔			
	2			tity identified in Section I, what is this	individual's	wlationship	with the
		5% or greater owner	☐ Pather	☐ Managing employee	□ Apert		
		Director/officer, title:		☐ Other (spec			
	8.	If the above individual is dir below:	restly associated with an ent	ty stertified in Section III, indicate the	name of the	E entity in th	ne space
		a. Legal business name of	entity as listed in Section III.	Pan A			
		What is this individual's r S% or greater owner Director/officer, title:	nile with the entity reported in	Section III? Check all that apply. Managing employee Other ispects	□ Agent		
	n,	report to the following questi	ions:				_
	t.		date of this statement has living fraud or alluse in any g	t the above individual been convicte overnment program?	d of any	□ Ves	DN:
		If yes, provide the date of the	ne conviction (mm/dd/yyyy) ,				
	2	Within sen years from the fraud or abuse involving a g	date of this statement, he overnment program in any o		lable for	□ Yes	□M
			nal judgment (mm/dd/yyyy):		-		
	2.	settlement in law of convicti	on for fraud or abuse involvin	t, has the above individual entered ng any government program?	i irin a	☐ Yes	□ Ne
		Does the above individual o	ne settlement (mm/dd/yyyy); sumently participate, or has i another state's Medicaid pro-	he or she ever participated, as a pri	peopler in	□ Yes	□ No
		If yes, provide the following					
		STATE		ME(S)		ANDION NUMBER	10

Question 18A (1-4) of DHCS 5300 combines all questions previously asked in DHCS 6207 I(J), II(A-E), & IV(B)(1-3) that pertain to sole proprietorship personal information. Thus eliminating any and all duplicate information requirements.



DHCS 5300 Page 7 (cont)

	In the	DWNERSHIP INTEREST table below, list any individual t	hat has 5% or more (dire	ct or indirect) owne	ership or control interest	or any partnership inter	rest, in the
	applic applic	ant/provider identified in question ant/provider must be reported in	on 1. In addition, all office this section. Attach a s	ers of the corporation	on, directors, agents and 18, for each individual	l managing employees listed below.	of the
	Numb	er of pages attached:					
		INDIVID	OUAL NAME		PERCENT (%) OF OWNERSHIP OR CONTROL	Social Security Number (SSN) (Required)	NPI TYPE 1
	1.						
	2.						
	3.						
	4.						
	5.						
18.	01	WNERSHIP INTEREST A	AND/OR MANAGIN	G CONTROL I	NEORMATION (INI	DIVIDUAL S)	
						-	
Α	. Identifi of the	ication Information - for Individua Partnership, Group Association	als with Ownership or Co , Corporation, Institution	ntrol Interest, Office or Entity.	ers, Directors, Managing	Employee(s), Partners	and/or Agents
	1. Fu	ill legal name (Last) (Jr., Sr., etc	:)	(First)			(Middle)
	_			4000			
	2. He	esidence address (number, stre	et)	(City)		(State) (Nine	-digit ZIP code)
	3. Da	ite of birth 4.	Driver's license number	or state-issued ide	ntification number		
			(Attach a current and le	giblecopy.)			
		the above individual related to a					Yes No
		es, check the appropriate box					
		Spouse Parent	Child	Sibling	Self 0	ther (explain):	
	Na	ame of individual:					
	6. If t	the above individual is directly iplicant/provider? Check all that	associated with the entity apply.	dentified in quest	ion 1, what is this individ	dual's relationship with t	he
		5% or greater owner	Partn		Managing employee	Agent	Self
		over a greater owner	Faiti	er	managing employee		
		Director/officer, title:	Fair	er	Other (s	pecify):	
	7. If t	Director/officer, title:	associated with an entity	identified in questi	Other (s		ce below:
	7. If t	Director/officer, title:	associated with an entity	identified in questi	Other (s		ce below:
	7. If t	Director/officer, title:	associated with an entity	identified in questi	Other (s		ce below:
	7. Ift	Director/officer, title: the above individual is directly Legal business name of entity What is this individual's role w	associated with an entity as listed in question 15: with the entity reported in	identified in questi	Other (s on 15, indicate the name	e of that entity in the spa	ce below:
	7. Ift	Director/officer, title: the above individual is directly Legal business name of entity What is this individual's role v 5% or greater owner	associated with an entity as listed in question 15:	identified in questi	Other (s on 15, indicate the name	e of that entity in the spa	ce below:
	7. Ift	Director/officer, title: the above individual is directly Legal business name of entity What is this individual's role w	associated with an entity as listed in question 15: with the entity reported in	identified in questi	Other (s on 15, indicate the name	e of that entity in the spa	ce below:
	7. If t a. b.	Director/officer, title: the above individual is directly Legal business name of entity What is this individual's role w 5% or greater owner Director/officer, title:	associated with an entity of as listed in question 15: with the entity reported in	identified in questi question 15? Chec r	Other (s on 15, indicate the name	e of that entity in the spa	ce below:
	7. If t a. b.	Directoriofficer, title: the above individual is directly Legal business name of entity What is this individual's role w 5% or greater owner Directoriofficer, title:	associated with an entity v as listed in question 15: with the entity reported in Partne	identified in questi question 15? Chec r [Other (s on 15, indicate the name	e of that entity in the spa	
	7. If t a. b.	Director/officer, title: the above individual is directly Legal business name of entity What is this individual's role w 5% or greater owner Director/officer, title:	associated with an entity or as listed in question 15: with the entity reported in Partne of this statement, has to add or abuse in any government.	identified in questi question 15? Chec r [Other (s on 15, indicate the name	e of that entity in the spa	ce below:



Questions 18A (5-7) closely mirrors the context provided in DHCS 6207 IV., B(6-8). However, note the checkbox "self" was added for the applicants/providers that this field applies to.



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B. Re	spond to the following qu	estions:		:	APPLICANT/PROVIDER BIFORMATION (Continued) LAPPLICANT/PROVIDER BIFORMATION (Continued)
1.	Within ten years from	the date of this statement, has the a	above individual been convicted of	any	J is the same and attended of all health case provides, such safety or not provided or the provided or the provided or the provided provided by the Provided or the provided p
	felony or misdemeanor i	nvolving fraud or abuse in any governm	nent program?	Yes No	Address (number count) (Oily) (class) (one-oigh 297 class) WHERE CATACOLS WARD WHERE CATACOLS WARD WHERE CATACOLS WARD
	If yes, provide the date	of the conviction (mm/dd/yyyyy):		-	K. Reapon'd to the Making quantum Tender T
				1	Eyes, provide the date of the connection (principley): 2. wereas was person or date and early extrement to eyes, the appropriation to previous health care of the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation to extreme the extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 2. Wereas was person or date and early extrement to eyes, the appropriation ever. 3. Wereas was person or date and early extrement to eyes, the appropriation ever. 3. Wereas was person or date and early extrement to eyes, the appropriation ever. 3. Wereas was person or date and extrement to eyes, the appropriation ever. 3. Wereas was person or date and extrement to eyes, the appropriation ever. 3. Wereas was person or date and extrement to eyes, the appropriation ever. 3. Wereas was person or date and extrement to eyes, the appropriation ever. 3. Wereas was person or date and extrement to eyes, the appropriation ever. 3. Wereas was person or date and extrement to eyes, the appropriation ever. 3. Wereas was person
					Fire, provide the date of first jumped throughput (mindage). White the same of the date of first jumped throughput (mindage). White the same of the date of first jumped throughput (mindage). White the same of the date of first jumped throughput (mindage). White the same of the date of first jumped throughput (mindage).
DHCS 5300 (rev.	11/16)			7	If we, provide the date of the settlement immobilishment
					Conyon to applicationary and profit part that you were participated as a provider in the federal program or another state in the least that the state of the least that the least the least that the least the least that the least th
					STAFE (LEAL AND SEA) PRODUCE MARRINGS
	•••••		• • • • • • • • • • • • • • • • • • • •	••••••	If you, the applicant/provider, are an unincorporated sole proprietor or an individual rendering provider adding to a group, proceed to
: '	fraud or abuse involvin	m the date of this statement, has the grant of the grant		ble for	Name you, the applicant/provider, ever been suspended from a Mediciani, bibliodical, or Mediciani Prime Tree
1	 Within ten years from settlement in lieu of co 	n the date of this statement, has the nyiotion for fraud or abuse involving am		□Yes □ No	If yes, attach-verification of exintationant and provide the following information:
-	Does the above indivi- state's Medicaid progri if yes, provide the folio	of the settlement (mm/dd/yyyy) dual currently participate, or has he or am?	she ever participated, as a prov		HYOU, the applicant/provider, are a partnership, corporation, sometiments, sometime
	If yes, provide the folio		NAME(S)	PROVIDER NUMBER(S)	Mocars Mocars Mocars
					 If in the in-dividual features, certificate, or when approved to provide health care of the applicant/provider work been supplied for revisable; □ Yes. □ Yes.
li .		al ever been suspended from a Medic		n7 CYes DNo	If you could notice of biometry admitted by the sales designed and willow confidentials from the first play in a control of the sale of the sales of
	If yes, attach verificati	on of reinstatement and provide the fo	llowing information:		Todds Activities (screened administration)
:	PROGRAM Medi-Cal Medicaid	PROVIDER NUMBER(S)	EFFECTIVE DATE(S) OF SUSPENSION	DATE(S) OF REINSTATEMENT(S), AS APPLICABLE	Co not have any questions, loses, loses, sets, blank Page 1 or 1 Co not have any questions, boses, lines, etc., blank
	Medicare Medicaid Medicaid				Page 3 of st. Page 3 of st. Discussion in this country and questioning, country, and, country, and, country, and for st. Page 3 of st.
	Medicare Medicare Has the above individ	ual's livense, vertificate, or other app	roval to provide health care ever	been suspended	N. OWNERSHIP BITTERST AND OR MANAGING CONTROL BRICHMATION (BIDWIDULALS) (Continued) IV. OWNERSHIP BITTERST AND OR MANAGING CONTROL BRICHMATION (BIDWIDULALS) (Continued)
		f licensing authority decision(s) and w have been restored and provide the fo	ritten confirmation from them that towing information:		B identification information - the Independent with Ownership or Control Interest, Officers, Directors, Managing Employee(s), Partners Build Agent of the Primerating, George Association, Congression, Consideration, C
	WHERE ACTION(8)	WAS ACTION	N(S)TAKEN	LICENSING AUTHORITY SACTION(S)	3 feacures somes common some (cm) classic research per const. If yes, attach werification of reinstatement and provide the following information:
li .				:	Tools wouth notice required. 4 Desir sizes a converse an applicable indicate a converse an applicable. The control of the con
	. Has the above individu provide health care wh	al otherwise lost or surrendered his or ite a disciplinary hearing was pending	her license, certificate, crother ap	proval to Ves 1No	6. In the above inclined to any inclined in the second of
:		the written confirmation from the licen have been restored and provide the follows:		EFFECTIVE DATE(S) OF	Questions 18B (1-9) are a combination of
li .	WHERE ACTION(S	АСТЮ	N(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY SACTION(S)	NOS CONTROL DE MANAGEMENT
				:	pages 2,3,8,& 9 of DHCS 6207. The
	• • • • • • • • • • • • • • • • • • • •		• • • • • • • • • • • • • • • • • • • •		5. The above individual is directly associated with an entit
					a larget harbonness comes of series to lived to Energy an larged to England to Series (1) reeeval usation of the sole proprietor entity
DHC5 5300 (re	v. 11/10)				as the same person as the
					* With the party for the first of the composition o
0.	Has the above indivi	dual's license, certificate, or other	approval to provide health or	re ever been disciplined by any	2. Without on the last from the dark or this substrated, has from the last frow the last from the last from the last from the last from the la
	If yes, include copies	of licensing authority decision(s), tion:	including any terms and condi	ions for each decision, and provide	Text. service the date of the
w	HERE ACTION(5) WAS TAKEN	ACTION(S) To	AKEN LI	EFFECTIVE DATE(S) OF CENSING AUTHORITY'S ACTION(S)	Page 18 Programme Control Cont
					4 De to de constitution de la co
_					Fye, provide the following information:
9.	List the name and ad individual also has a	dress of all health care providers, ownership or control interest.	participating or not participating	g in Medi-Cal, in which the above	A fixing area of reads use procedure (minor any fixing to charact names) A Advance Annual (minor street) A Advance Annual (minor street) A Advance Annual (minor street) Advance Annual (minor street)
::=	If additional space is no	seded, attach additional page (labeler ealth care provider (Include any fictible	"Additional question 10, item 9"		
<u>, l</u>	B. Address (number, 1		(City)	(State) (Nine-digit ZIP code)	Proceed to Section V. On not leave any questions, boses, fores, etc., blook. Do not leave any questions, boses, fores, etc., blook.
1			13-47		the state of the contract of t



DHCS 5300 Page 9 (cont)

licensing authority?		approval to provide health care ever been disciplined by any Yes No				
If yes, include copies of lic the following information:	ensing authority decision(s), including any terms	and conditions for each decision, and provide				
WHERE ACTION(S) WAS TAKEN	ACTION(S) TAKEN	EFFECTIVE DATE(S) OF LICENSING AUTHORITY'S ACTION(S)				
	s of all health care providers, participating or not nership or control interest. If none, check h					
individual also has an own		nere.				
individual also has an owr If additional space is needed	nership or controlinterest. If none, check h	nere.				

EXECUTION OF THIS AGREEMENT BETWEEN AN APPLICANT OR PROVIDER HEREINAFTER JOINTLY REFERRED TO AS "PROVIDER" AND THE DEPARTMENT OF HEALTH CARE SERVICES HEREINAFTER "DHCS". IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE DENTI-CAL PROGRAM PURSUANT TO 42 UNITED STATES CODE, SECTION 1396a (a) (27), TITLE 42, CODE OF FEDERAL REGULATIONS, SECTION 431,107, WELFARE AND INSTITUTIONS CODE, SECTION 14043.2, AND TITLE 22, CALIFORNIA CODE OF REGULATIONS, SECTION 51000.30(a)(2).

AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE DENTI-CAL PROGRAM, PROVIDER AGREES TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BYREFERENCE:

- 1. Term and Termination. This Agreement will be effective from the date applicant is enrolled as a provider by DHCS, or, from the date provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHCS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program unless and until such time as Provider is re-enrolled by DHCS in the Medi-Cal program. DHCS may immediately terminate this Agreement for cause if Provider is suspended/excluded for any of the reasons set forth in Paragraph 26(a) below, which termination will result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Medi-Cal program. During any period in which the provider is on provisional provider status or preferred provisional provider status. DHCS may terminate this agreement for any of the grounds stated in Welfare and Institutions Code Section, 14043 27(c)
- 2. Compliance with Laws and Regulations, Provider agrees to comply with all applicable provisions of Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 14200), and any applicable rules or regulations promulgated by DHCS pursuant to these Chapters. Provider further agrees that if it violates any of the provisions of Chapters 7 and 8 of the Welfare and Institutions Code, or any other regulations promulgated by DHCS pursuant to these Chapters, it may be subject to all sanctions or other remedies available to DHCS. Provider further agrees to comply with all federal laws and regulations governing and regulating Medicaid providers.
- 3. National Provider Identifier (NPI). Provider agrees not to submit any claims to DHCS using an NPI unless that NPI is appropriately registered with the Centers for Medicare and Medicaid Services (CMS) and is in compliance with all NPI requirements established by CMS as of the date the claim is submitted. Provider agrees that submission of an NPI to DHCS as part of an application to use that NPI to obtain payment constitutes an implied representation that the NPI submitted is appropriately registered and in compliance with all CMS requirements at the time of submission. Provider also agrees that any subsequent defect in registration or compliance of the NPI constitutes an "addition or change in the information previously submitted" which must be reported to DHCS under the requirements of California Code of Regulations, title 22, section 51000 40
- 4. Forbidden Conduct. Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare and safety of any Medi-Cal beneficiary, or the fiscal integrity of the Medi-Cal program.

DHCS 5300 (rev. 11/16)

MEDI-CAL PROVIDER AGREEMENT FOR STATE USE ONLY Do not leave any questions, lines, etc. blank. Enter N/A if not applicable to yo Every applicat and provide must assess recovering. DACS SEVS. The spraper identification number may be a Tapaper Identification Number (CNI) or a scotal associal scotting for site propieters.

Question 18B (9) is the beginning of the provider agreement clause. Although the context was not changed the text was relocated for ease of reading and completion.



DHCS 5300 Page 10-15

- Record Kepping and Retestion. Provider agrees to reads, below out credition in a policitation and recitory morars and the record's preferrable, such records as the records of the Red called to the period action of all services, goods, explices, and inservices provided to Medic-Cull beneficiaries, including, but not limited to b, the records described in Section 5-100.

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- by the Scoretary or the Medicaid agency, full and congette information about the centership of any subcontractor with alrow the provider has not business transactions totalising more than \$25,000 during the 12-month pend ending or the date of the request, and any significant business transactions between the provider and any wholly cented supplier, or between the provider and any significant business transactions between the provider and any wholly cented supplier, or between the provider and any subcontractor, unknife the function bened ending on the date of three-provider.
- Unancounced White by DRCS, AG and Secretary, Provider agrees that DRCS. AG and/or Secretary may make of determining whether enrollment, confined enrollment, or certification is warranted, to investigate and protected by against the Med. Call program, to investigate enrollment, or certification is warranted, to investigate and protected bands against the Med. Call program, and one processor in the secretarion of the Med. Call program and/or the payment under the Med. Call program, and/or an necessary for the administration of the Med. Call program and/or the little against, an other in Welfers and Intelligence of Secretary or any agent, meetings of the Med. Call program of the Secretary or any agent, meetings or custom thereof, shall be grounds for immediate suspension of provider from pathogenists in the Med. Call program.
- services not as to need provider for Franci of Abuse. Provider carries and, at the time this Agreement was signed, it was not under investigations of Provider for Franci of Abuse. Provider carries that, at the time this Agreement was signed, it was not under investigation to that or statue private the Support A (commencing with Section 455, 12) of that 610 of Trias 420 and agrees to notify Drick's different to the Abuse and Abuse an
- Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability, Provider certifier that it and its owners, officers, reretors, enjoyees, and agents, has not (1) been convicted of any felony or middemanor involving floats or abuse in any government program, within the last ten years, or (2) been convicted of any felony or middemanor involving floats or abuse or any patient, or (3) been convicted of any felony or middemanor involving the double of any felony or middemanor involving the double of any patient, or (3) been convicted of any felony or middemanor substantially related to the qualifications, inscribed of a growder, or (4) referred this a settlement in less of conviction for fload or abuse, within the last float.

The outlined pages, 10 through 15, of the DHCS 5300 are a continuation of the agreement clause, which mirrors the text in DHCS 6208. Therefore, no significant changes were made.

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- ing Law. This Agreement shall be governed by and interpreted in accordance with the

- 36. Severability. If one or more of the provisions of this Agreement shall be invalid, illegal, void, or unen

- Return of Payment for Services Otherwise Covered by the Medic Cal Program. Provider agrees that any beneficiary who has paid Provider for heads care services, goods, supplies, or merchandes developed the Medic Cal program received by the Inventicary shall be entitled to a prompt intern from Provider of any part of the payment which meets any authorities payment under Welder and Intelligence Codes, Section 5410 for 1931 (2015). So the Payment of the Pay

- hisher pad or deligated lability for health care services, goods, supplies, or merchander, or to establish eligibility. Complaines with Billing and Claims Repetiments. Provider agrees that it shall comply with all of the Billing and claims represent the provider of the

- The provider has provided material information that was false or misleation at the time it was provided
- The provider failed to have an established place of lusainess at the fusieness address for which the application package review conducted parsuant to this article or a statutior or regulation governing the Medi Call program, valess the practice of the providers profession of others of services, pools, applies, or mechanise is such that services, goods of the providers provided to the providers provided by the providers provided to the providers provided pro

The parties agree that this agreement is a logal and binding document and is fully enforceable in a court of compet jurisdiction. The provider signing this agreement warrants that he/she has read this agreement and understands it. Check here if you are the same person identified in term 19



DHCS 5300 Page 15 (cont)

knowledge of such a p the non-applicable pr	provision shall promptly inform the other of the	any way be affected or impaired. Either party having e presumed non-applicability of such provision. Should t, the Agreement shall be terminated in a manner
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	I. APPLICANT/PROVIDER INFORMATION	 To review the Tate 22 provider enrollment regulations, please visit the Medi-Cal Website (<u>see</u> "Provider Enrollment" link. It is the responsibility of the applicant/provider to compty with all Cal. 	4. "Managing employee" means a general manager, business manager, administrator, director, or other individ
	II. UNINCORPORATED SOLE-PROPRIETOR OR INDIVIDUA		exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation applicant or provider. All managing employees must be included in this section.
	ADDING TO A GROUP	Section I; Applicant/Provider Information 1. All applicants and providers must complete this Section unless they are eligible to use the	 List the National Provider Identifier (NPI) of each individual with ownership or control interest or any partnership in the applicant/provider identified in Section I. In adultion, all officers of the corporation, directors, agents and in
	III. OWNERSHIP INTEREST AND/OR MANAGING CONTROL	Application/Disclosure Statement/Agreement for Physician/Allies/Dental Providers' (Di Ordering/Referring/Prescribing Provider Application/Agreement/Disclosure Statement for	employees of the applicant/provider must be reported in this section.
	IV. OWNERSHIP INTEREST AND/OR MANAGING CONTROL	Practitioners" (DHCS 8219).	 Disclosure of social security number is mandatory. (See Privacy Statement at bottom of page 15)
	V. SUBCONTRACTOR INFORMATION AND SIGNIFICANT B	Rendering providers joining a group who are not eligible to use the "Medi-Cal Rendering Statement/Agreement for Physician/Allect/Dental Providers" may leave parts E-H blank if pa	Section V: Subcontractor Information and Significant Business Transactions 1. "Subcontractor" means an individual, agency, or organization:
		If applicant leases the location where services are being rendered or provided, please at lease agreement.	a. To which an applicant or provider has contracted or delegated some of its management functions or responsi
	VI. INCONTINENCE SUPPLIES	 In California, a domestic or foreign limited liability company is not permitted to render profit Corporations. Code. Sections. 13401. subdivision. (a). and. 13401.3. See California. 	providing healthcare services, equipment, or supplies to its patients. b. With whom an applicant or provider has entered into a contract, agreement, purchase order, lease, or lease.
	VII. PHARMACY APPLICANTS OR PROVIDERS	17791.04(e).	property, to obtain space, supplies, equipment, or services provided under the Medi-Cal Program. 2. "Significant business transaction" means any husiness transaction or series of transactions that involve her
California Department of	VIII. DECLARATION AND SIGNATURE PAGE	Section II: Unincorporated Sole-Proprietor or Individual Rendering Provider Adding to a	 agrindrant business transaction means any tusiness transaction or series or transactions that involve her services, goods, supplies, or merchandise related to the provision of services to Medi-ctal beneficiaries that, during facel year, exceed the leaser of \$25,000 or 5 percent of an applicant's or providers state operating expenses.
HealthCareServices		Disclosure of social security number is mandatory. (See Privacy Statement at bottom of page 1	fiscal year, exceed the lesser of \$25,000 or 5 percent of an applicant's or provider's total operating expenses. 3. "Wholly owned supplier" means a supplier whose total ownership interest is held by an applicant or provider or by a
		Section III: Ownership Interest and/or Managing Control Information (Entities)	persons, or other entity with an ownership or control interest in an applicant or provider.
		 To determine percentage of ownership, mortgage, deed of trust, note or other obligation, then the obligation is multiplied by the percentage of the disclosing entity's assets used to secure. 	Section VI Incontinence Supplies
applicant or provider must complete and submit a current Medi-Cal Disclosure a complete application package for enrollment, continued enrollment, or certifical		If A owns 10 percent of a note secured by 60 percent of the applicant's or provider's asset assets equates to 6 percent and shall be reported pursuant to California Code of Regulatio	Applicant or provider must check "Yes" or "No." M "Yes," complete AC.
		Gonversely, if 0 owns 40 percent and shake secured by 10 percent of the applicant's or prox provider's assets equales to 4 percent and need not be reported.	Section VE Pharmacy Applicants or Providers
ant:		"Indirect generalitio interest" means an generalitio interest in any entity that has an general	All pharmacy applicants or providers must complete this Section.
NEW APPLICANTS: Failure to disclose complete and accurate information		provider. This term includes an ownership interest in any entity that has an indirect owner provider. The amount of indirect ownership interest is determined by multiplying the per	Section VIII: Declaration and Signature Page
liment and imposition of a three-year reapplication bar.		provider. The amount of indirect elementary interest is determined by multiplying the per- entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 perc or provider. As interest equates to an 8 percent indirect ownership interest in the app.	All applicants or providers must complete this Section.
CURRENTLY ENROLLED APPLICANTS: Failure to disclose complete and as		or provider, A's interest equates to an 8 percent indirect ownership interest in the app reported pursuant to California Code of Regulations, Title 22, Section 51000.35. Convers- stock of a corporation, which owns 5 percent of the stock of the applicant or provider. B's	 Legal name of applicant/provider must match name listed on associated application package. The signature must be an individual who is the sole proprietor, partner, corporate officer, or an official represent
tio desired describeding of all horizons addresses and the impact of the control		stock of a corporation, which owns 5 percent of the stock of the applicant or provider, B's indirect ownership interest in the applicant or provider and need not be reported.	governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider. See CCR Section 51000.30(a)(2)(B).
t in denial, deactivation of all business addresses and the imposition of a <u>three-</u> Department is required to report the termination of your participation in the Med		 "Denership interest" means the possession of equity in the capital, the stock, or the profits of 	4. An original signature is required. Stamped, faxed, and/or photocopied signatures are not acceptable.
It in denial, deactivation of all business addresses and the imposition of a <u>three</u> . Department is required to report the termination of your participation in the Med fedicare & Medicaid Services and to other States' Medicaid and Children's Heal			
It in denial, deactivation of all business addresses and the imposition of a <u>Bree-</u> Department is required to report the termination of your participation in the Med fedicare & Medicaid Services and to other States' Medicaid and Children's Heal usert to United States Code, Title 42, Sections 1396a(kb)(6) and 1962(kb)(6) and		 All entities with managing control of applicant/provider must be listed in this Section. 	 Disclosure Statement must be notarized by a Notary Public except for those applicants and providers licensed pullularises and Professions Code. Division 2, beginning with Section 500. For example: Physicians. Pharmacy:
In derais, deactivation of all business addresses and the imposition of a <u>Bree-</u> Department is required to report the termination of your participation in the Medi Indicace & Medicaid Services and to other States' Medicaid and Children's Heal acrat to United States Code, Tele 42, Sections 1396a(kk)(6) and 1902(kk)(6) an ulations, Title 42, Section 1002.5(b).		 All entities with managing control of applicant/provider must be listed in this Section. List the National Previder Identifier (NPI) of each Islated corporation, unincorporated associate having 5% or more (direct or indirect) covanciating or control indirect. or any partnership or 	Chirocractors, Osteopaths, Certified Nurse Mideryes, Nurse Practitioners and Dentists do not need to notarize to
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It in derival, descrivation of all business addresses and the imposition of a green- Department in recognition of proof the fermional or your participation in the Medical Recidence & Medicald Devices and to other State's Medicald and Children's Hest and to United States Code, 1784 47, Section 1590(24)(4) in 810(2014)(5) an allotine, Titol 42, Section 150(2-24), and allotine, Titol 42, Section 150(2-24) and addresses the section of the se		4. All entities with managing control of application/provider must be fished in this Section. 5. List the National Provider Netherlish (Prif) of each list has proposation, universided associated having 5th, or more (lotted or indirect) ownership or control indexes. or any partnership in the price of the pr	Chiropractors, Osteopaths, Certified Nurse Mideives, Nurse Practitioners and Dentists do not need to notarize t Durable Medical Equipment (DME) providers, Prosthetics, Orthotics, Medical Transportation providers, etc., must
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Questions/Comments